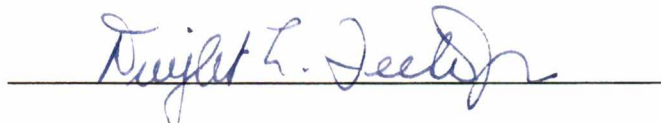


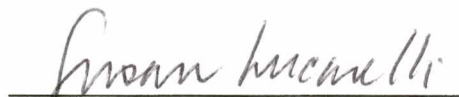
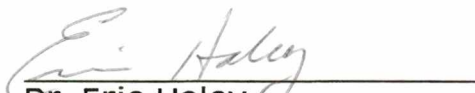
To the Graduate Council:

I am submitting herewith a thesis written by Deborah Lucille Shipley entitled "Physicians' Disclosure of Their HIV Status: Private Fact versus Duty To Inform." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Communications.

A handwritten signature in blue ink, reading "Dwight L. Teeter, Jr.", is written over a horizontal line.

Dr. Dwight Teeter, Jr., Major Professor

We have read this thesis and
recommend its acceptance:

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Dr. Susan LucarelliA handwritten signature in black ink, reading "Eric Haley", is written over a horizontal line.
Dr. Eric Haley

Accepted for the Council:

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Associate Vice Chancellor and
Dean of the Graduate School

PHYSICIANS' DISCLOSURE OF THEIR HIV STATUS:
PRIVATE FACT VERSUS DUTY TO INFORM
A LAW ANALYSIS

A Thesis
Presented for the
Master of Science Degree
The University of Tennessee, Knoxville

Deborah Lucille Shipley
August 1995

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For Goldine and Anna

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My dear parents, Bill and Pat, bring special meaning to this day. I am deeply grateful for all the sacrifices they have made for me and for their belief in me.

And, to my fiance' and best friend, Rock, for his abiding love and devotion; for his encouragement and faith in me; and for dreaming my dreams with me.

Abstract

Disclosure of a health care provider's HIV status continues to be a major point of contention. Because AIDS now is viewed as a death sentence, it presents unique medical and social dilemmas.

In an attempt to put the controversy over HIV-status disclosure by health care providers in some perspective, the primary focus of this study will be to examine a number of significant reported court decisions on the legal responsibility of health care workers to reveal their HIV status to their patients. Thus, this study is an interpretative examination of responses by some courts to a significant medical, ethical and social policy issue facing the health care industry and the legal community in the 1990s. As a result, this thesis--in significant part--is about a constitutional right of privacy, illustrating how the explosion of the AIDS virus is causing an evolution in privacy law and, ultimately, in public policy.

Lessons drawn from these cases will be used by the author as a professional in healthcare administration to suggest--tentatively--how a hospital might protect itself **and** the rights of its patients **and** health care providers.

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INTRODUCTION

"It is 80 degrees in the Florida dusk, but Kimberly Bergalis huddles under a quilt on the couch of her family's living room. At 65 pounds, she is half her normal body weight. Her skin is chalk white and her eyes stare blankly at the television. She is in the final stages of an AIDS-related tuberculosis that wastes body and brain."¹

Days later, Kimberly Bergalis died as a result of AIDS nearly two years after being infected by her dentist, Dr. David Acer, who died of AIDS in September of 1990.

Stories such as this one from the July 1, 1991, issue of Newsweek touched Americans deeply, fueling the controversy over whether physicians should be required to reveal their HIV status to their patients. It is a debate which, nearly four years later, remains unresolved to the general satisfaction of our society.

Bergalis, as far as we know, was not the stereotypical AIDS (Acquired Immunodeficiency Syndrome) victim. In a portion of one of her letters published in Newsweek, she said she "never used IV drugs, never slept with anyone and never had a blood transfusion."² (The article indicates that when Bergalis was first diagnosed with HIV, health officials investigating her case relentlessly looked for indicators of the "traditional" explanations as

to how she became infected, but those avenues proved dead-ends.)

Even though "we do not know and will probably will never know the exact mechanism of HIV transmission in this dentist's office," concedes William L. Roper, M.D., director of the Centers for Disease Control and Prevention (CDC) "one of the many theories, the most commonly accepted is that transmission occurred. . .because of her dentist's apparent 'slipshod sterilization.'"³

The public's outrage at the height of the Bergalis story bordered on hysteria, prompting drastic actions--and reactions--by the medical and legal communities. Legislators in several states introduced bills that would force all HIV-positive doctors to disclose their status to their patients. Aggrieved patients began distrusting their physicians and filed lawsuits after learning their physicians were infected, even though the patients had tested HIV-negative.

Across the United States, legislators' attempts to enforce or mandate restrictions were varied. A bill proposed in New Jersey, for example, provided criminal sanctions of \$1000 in fines and imprisonment for a maximum of six months against health care workers who performed invasive procedures without disclosing their HIV status to their patients.⁴ Lawmakers in Delaware, Pennsylvania, Maryland and New Hampshire have considered bills that would require health care workers to undergo compulsory HIV

testing.⁵ In its 1991 guidelines regarding universal precautions, the CDC opposed mandatory testing. (These guidelines are outlined in detail later in Part III.) And, New Hampshire enforces a law that prohibits health care workers who know they are infected with HIV from performing any exposure-prone* procedures unless they have filed a letter of application with the director of health.⁶

At the end of 1993, New York enacted a law establishing a state advisory panel to evaluate HCW's and to recommend practice restrictions or modifications. Texas has taken a similar approach.⁷

The CDC's definition, including a recommendation of its universal precautions, has been used as a springboard for formulating laws in several states including Tennessee, Arkansas, California and Pennsylvania. States considering such measures in 1995 include Delaware, Massachusetts, Missouri and Michigan.⁸

These examples provide a testimony as to this nation's reaction to the Kimberly Bergalis tragedy and to her campaigns for governmental regulations to protect others like her. One could not

*The CDC has defined "exposure-prone" as procedures that include digital palpitation of a needle tip in a body cavity or the simultaneous presence of the HCW's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site.

help but be moved by her anguished testimony before Congress, pleading for mandatory HIV-testing and status disclosure of all physicians. Her poignant letters to family and ultimately to the nation detailed her most intimate thoughts and feelings. Excerpts of her letters were read on national television and published in magazines such as Newsweek after her death. She described her suffering and helplessness; her bitterness and devastation because of AIDS. As a postscript to one of her letters, Bergalis wrote: "If laws are not formed to provide protection, then my suffering and death was in vain."⁹

On an emotional level, the need for disclosure may seem obvious. Had there been established laws restricting (or prohibiting) Dr. Acer's practice of dentistry so that his patients' body fluids were not exposed to infection, and if he, in fact, would have complied with those laws, the likelihood of him transmitting HIV (as we know it) to his patients would have been impossible. And Kimberly Bergalis might still be alive.

Certainly, emotion is a force to be reckoned with, especially when peoples' lives are compromised. Emotion often determines why persons do some of the things they do. "Gut instincts" center around emotion. Belief systems are woven integrally into emotions. Emotion is one thing. Hysteria is another. It serves no

real purpose except to fuel paranoia and illogical thinking. But, emotion is but one part of the issue.

In the controversy over requiring physicians to reveal their HIV status to their patients, have states and legislators reacted by a "knee-jerk" impulse as a result of the Bergalis tragedy? Has the formulation of these laws been the result of hysteria and paranoia? Is there a legitimate, legal obligation for HIV-positive physicians to "level" with their patients prior to rendering health care? Even though the primary focus of this thesis is the legal component of this issue, the questions of moral and ethical obligations cannot be omitted; nor will they be.

While no irreverence to Bergalis' memory is intended, for the sake of practicality, reasonable effort must be made to go beyond the emotional aspects of the issue in order to try to see it objectively. If attempts are to formulate guidelines about HIV-status disclosure of physicians to their patients, then the controversy must be examined from differing angles, attempting not to give undue weight to emotion.

NOTES INTRODUCTION

1. Gentile, Bill, "Doctors and AIDS," Newsweek, July 1, 1991, p. 49.
2. Ibid, p. 51.
3. Crane, Mark, "How Doctors Really Feel About AIDS Testing," Medical Economics, December 16, 1991, p. 19.
4. "AIDS and the Law", A Publication of the American Bar Association, 1994, p. J-5, citing MD S.B. 7 (1992), NJ A.B. 751 (1994), NY A.B. 4835 (1991).
5. Ibid, p. J-6, citing DE H.B. 191 (1991), MD S.B. 18 (1992), NH H.B. 1404 (1992), PA H.B. 743 (1993).
6. Ibid, citing NH SB 123, Chapter 83.
7. State Advisory Panel on HIV/HBV Infected Health Care Workers, NY St. Ann. L. 1993, C. 731, S. 2760 (1993).
8. "AIDS and the Law", A Publication of the American Bar Association, 1994, p. J-5, citing DE S.B. 275 (1992), MASS H.B. 1303 (1992), MI S.B. 633 (1992), MO H.B. 1514 (1992).
9. Gentile, p. 52.

PART I
THESIS OVERVIEW: STATEMENT OF THE PROBLEM

In an attempt to put the controversy over HIV-status disclosure by health care providers in some perspective, the primary focus of this study will be to examine a number of significant reported court decisions on the legal responsibility of health care workers to reveal their HIV status to their patients. For purposes of discussion in this thesis, the scope of the definition of health care provider is limited to those individuals classified as physicians and dentists, herein referred to collectively as "physicians."

Many physicians assert that they have the right to know the HIV status of their patients because the risk of transmission of the HIV virus from patients to their physicians poses a much greater risk than the other way around.¹ "Indeed, the risk of getting AIDS from a doctor during surgery is about the same chance that a person will have a fatal accident on the way to the hospital."²

Dr. Robert Lowenfels of New York Medical College "calculated that the risk of transmission from an HIV-infected surgeon to a patient is about one in 48,000. The risk closely resembles the risk of a vehicular fatality during transportation to and from the hospital," he concluded. But, it seems that the risk of transmission from a patient to a physician is much higher. "In contrast to the five Florida cases, (There were four others reportedly infected by Dr.

Acer) there are 40 known cases of health care workers around the country who have gotten AIDS from patients."³ So, even though the statistics indicate that the chances of a patient contracting AIDS from an HIV-infected physician is virtually nonexistent, the operative word here is "virtually." There **is** the possibility of transmission.

Then, after transmission, begins the process of a slow, painful, almost certain descent to death. HIV eventually becomes full-blown AIDS, devouring the body's immune system, rendering it helpless to fight any viral intrusion. There are a few cases of long-term survival. According to Dr. Jay Levy of the University of California, San Francisco, "Physicians have been tantalized by the puzzle of people with longstanding HIV infections who have not developed symptoms [of AIDS]." His research has shown that "the immune systems [of these individuals] naturally produce a substance which temporarily halts replication of the virus, enabling the body's system to ward off the virus's ravages for as long as a decade."⁴

But such cases are rare. According to Dr. Anthony Fauci for the greater population of AIDS sufferers, death comes within four to seven years from the actual diagnosis of AIDS. Research presented in 1993 at the Ninth International Conference on AIDS revealed that the HIV infection can lay in a sort of "dormant" period

for up to six years after actual transmission. It is during this period that the carrier is typically asymptomatic and HIV continues to replicate, silently eating away at the body's immune system. Once the symptoms are there, so too is full-blown AIDS.⁵

Still, from a public policy perspective, former Surgeon General C. Everett Koop minimized the possibility of a health care provider infecting a patient: "A patient's chance of becoming infected from an HIV-positive caregiver is essentially nil."⁶ The Centers for Disease Control and Prevention (CDC) estimates a patient's risk of contracting the disease from an infected surgeon at no more than one in 42,000, and possibly the odds against infection are higher than that.⁷ The April 14, 1993 issue of the *Journal of The American Medical Association (JAMA)* reported: "As of December 1992, more than nineteen thousand patients of HIV-infected HCWs [health care workers] have been tested in look-back studies and no patient has [been] found to be infected through iatrogenic transmission [induced by a physician]."⁸

In the atmosphere of alarm generated by AIDS, these statistics seem to offer little comfort to the general public. As Newsweek's Bill Gentile wrote, "Like everything else about the AIDS epidemic, there's a big gap between knowledge and emotion."⁹ There still is a brewing controversy over whether health care providers should

be required legally to reveal their HIV status to their patients. Various spokespersons maintain on behalf of "the public" that it deserves to know a physician's HIV status.

This sentiment is not limited just to the general public. It also is shared by some members of the medical community. For example, according to Dr. Sanford Kuvin, vice chairman of the National Foundation for Infectious Diseases in Washington, D.C., "The inherent right to know--for patient and doctor alike--always has to supersede confidentiality. The doctor doesn't have to put up a signboard, but there has to be informed consent if he is going to do invasive procedures. First, do no harm is the absolute bedrock of medicine. The Kimberly Bergalises of this world are avoidable."¹⁰

However, disclosure of a health care provider's HIV status continues to be a major point of contention. Because AIDS now is viewed as a death sentence, it presents unique medical and social dilemmas.

"In past epidemics, infected doctors were never required to disclose their status to their patients," says Sheila Rothman, a medical historian at the Center for the Study of Society and Medicine at Columbia University.¹¹ Certainly there are consequences inherent in HIV-status information becoming "public

knowledge." It appears that the fear of death from AIDS often is equivalent to if not exceeded by the fear of society's reaction to it once HIV status becomes "public knowledge."

AIDS sufferers lose more than their life. They lose their dignity, too. Often, they must endure more than the pain of the disease. They must endure the pain of moral judgment as well, often viewed as separate from the "mainstream" because they are afflicted with the disease transmitted by direct exposure to HIV-positive blood or other body fluids. The disease is thought to have originated in Africa, but was first observed in the United States in the gay and intravenous drug-user communities. As Bill Gentile wrote in Newsweek:

Physicians who willingly disclose their illness can pay a terrible price. Dr. Hacib Aoun's entre into the nightmare world of AIDS came without warning, heralded only by a sharp crack of a breaking test tube and the sight of HIV contaminated blood dripping over his cut finger. In December 1986, three years after that day, the Baltimore cardiologist was diagnosed with full-blown AIDS. Administrators at the hospital where he was training refused to renew his contract.¹²

Aoun has not been able to find a job since 1986 and is bitter. He says that "HIV-positive doctors are treated like lepers. The one

thing that I am not doing now is the thing I love most in life and that is taking care of people, because medicine has no place for those who are HIV infected."¹³

From a legal perspective, it might appear that the disclosure of HIV status could be construed as defamation because "defamation is communication that exposes persons to hatred, ridicule, or contempt, lowers them in the esteem of others, causes them to be shunned, or injures them in their business or their calling."¹⁴ However, one criterion of actionable defamation requires that the information being revealed actually must be **false**.

If someone, in fact, is actually HIV-positive, revelation of that information cannot, by definition, be construed as defamation because provable truth is a complete defense. But, there may be reason to question whether the truthful revelation of private facts is legally permissible. As privacy law scholar Don R. Pember has written, although truth, generally, is a defense to defamation, the "private facts" branch of privacy law means that persons may be able to bring successful lawsuits for the truthful publication of private facts. In that branch of the privacy tort, proof of truth is not necessary to collect monetary damages.¹⁵

Professor William Francois concurs that the private facts tort

is "concerned with the publication of truthful, but private, information of an embarrassing nature about an identifiable individual. It can be distinguished from defamation in that public disclosure involves truthful information, whereas defamation involves false information which injures a person's reputation."¹⁶

In Rodney Smolla's Law of Defamation, he states:

Unlike defamation, which defines "publication" to accompany communication of the defamatory statement to someone other than the plaintiff, the publication required for the tort of publication of private facts is broader--there must be sufficient publicity given to the facts so that they may be considered disclosed to the public at large.¹⁷

AIDS is an intensely private disease. Perhaps because of its first association with the gay and intravenous drug-user communities, it appears that any connection with the AIDS virus seems to invite social stigma and--however reprehensible--"moral" indignation.

Whether or not health care providers should reveal their HIV status is an emotionally-charged controversy that in the mid-1990's continues to baffle judicial minds. When a major problem or controversy arises in the United States, public outrage may give rise to legislative attempts to try to resolve or ameliorate that problem. As suggested earlier, that process may be seen in the wake of the

death of Kimberly Bergalis.

As Gentile noted in the July, 1991, Newsweek article, "Although the five [Acer patients] are still the only patients known to have gotten AIDS from a physician or dentist, their cases have turned the impossible into a frightening reality." Gentile also observed that, "Some health officials say the public reaction in recent months bordered on hysteria. Legislators in several states have introduced bills calling for all HIV-positive doctors to disclose their status to all their patients."¹⁸

At this writing in mid-1995, such legislation has not become federal law. Rather, as discussed in the introductory portion of this thesis, legislative actions have been on the state levels. But, there are certain drawbacks to this type of "piecemeal" lawmaking. Variations from state to state and alterations imposed by court challenges result in inconsistent policies.

However, if Congress were to enact a national statute to specify when and how physicians must reveal their HIV status, it is likely that multiple court challenges based on perceptions of privacy could alter or overturn such a statute. This kind of legislation, not incidentally, could generate constitutional challenges based on a constitutional right of privacy.

Although privacy is not mentioned in the Constitution of the

United States, the Supreme Court has held since 1960 that there is a constitutional right to privacy against some intrusive actions by government.¹⁹ Thus, state action such as a statutory compulsion for a physician or dentist to reveal private information could be challenged as violating a right to privacy guaranteed by the Constitution of the United States. Statistical evidence that indicates that health care providers who are HIV-positive are a negligible threat to public safety also could be used to suggest arguments for nondisclosure.

On the other hand, the pro-disclosure side of a constitutional confrontation as outlined above might well include a due process argument. Under the Fifth and Fourteenth Amendments, the federal and state governments are forbidden from taking life, liberty or property without due process of law. Emotions evoked by the AIDS epidemic would most likely find their way into pro-disclosure arguments that "allow" the government to look at statistics, but ultimately it is the protection of the individual that courts may be expected to value most highly.

There is a moral responsibility and probably a legal right to gather information that a person needs for his or her own protection and self-defense. The Constitution was designed to protect individuals against government, not to mandate statutes

that could defeat the individual's efforts at self-preservation.

The relatively new constitutional right of privacy is pertinent to discussions of any state-mandated compulsions to disclose the "private facts" of health care providers' medical conditions. As a result, this thesis--in significant part--is about a constitutional right of privacy.

Also, this thesis is a study of the first uncertain attempts of courts to wrestle with privacy issues as articulated in tort actions: lawsuits seeking monetary damages in the "private facts" subdivision of the privacy tort. Oftentimes, in a developing area of law, court decisions--decisions which award or deny money to plaintiffs or defendants--in effect serve as a substitute for thoughtful policy formulation. That is, much as the soothsayers of old who studied the stars or chicken entrails to predict the future, medical policy formulators will look for guidance in the often confusing (and contradictory) decisions of the courts. But, one place to start would be with the 1980 *Richmond Newspapers, Inc. v, Virginia* case, in which the Supreme Court of the United States came closest to finding a constitutional right to gather information.²⁰

Perhaps in an attempt to keep this issue removed from the court system and to protect the public, the Centers for Disease Control and Prevention (CDC) in its 1991 policy formulations

suggested that health officials should decide on a case-by-case basis whether an infected health care worker poses a risk to patients.²¹ And, the American Medical Association (AMA) stated in its January, 1991, policies an ethical responsibility of infected physicians not to perform any procedures that "pose an identifiable risk of transmission."²²

Nevertheless, this issue has been framed as a privacy issue, which involves the courts, in terms of pro-disclosure vs non-disclosure of health care providers' HIV status. Courts operate in the framework of "trial by combat;" the basic idea being that the more powerful (or convincing) antagonist should win. The question of whether courts are the proper agencies to set public policy is a real one.

The adversarial system of jurisprudence creates a problem when there is an ethical choice at the center of a controversy because often, individuals and institutions design their "code of conduct" not to do what is right, but to avoid the financial and the potential personal expense of litigation. A lawsuit, as the cynical journalist Ambrose Bierce said, is "'a machine which you go into as a pig and come out as a sausage.'"²³

Because the issue of revealing a physician's HIV status has essentially been left up to the court system, this thesis, then, looks

at some examples of the courts' early efforts to deal with the issue of whether physicians' HIV status legally may be withheld from patients.

NOTES PART I

1. Gentile, Bill, "Doctors and AIDS," Newsweek, July 1, 1991, p. 50.
2. Crane, Mark, "How Doctors Really Feel About AIDS Testing," Medical Economics, December 16, 1991, p. 19.
3. Gentile, p. 51.
4. Ibid., p. 56.
5. Thomas, David, "What Causes Disease Progression?--New Insights Into How HIV causes AIDS.," A Special Report on the Ninth International Conference on AIDS., *Positively Aware*, Summer 1993, p. 5.
6. Lippmann, Helen, "HIV and Professional Ethics: Nurses Speak Out," RN, June 1992, p. 29.
7. Ibid.
8. Mishu, Ban and William Shafer, "HIV-Infected Surgeons and Dentists: Looking Back and Looking Forward," 269 Journal of the American Medical Association, 1843 (April 14, 1993).
9. Gentile, p. 51.
10. Ibid., p. 54.
11. Ibid.
12. Ibid., p. 56.
13. Ibid.
14. Teeter, Dwight L., Jr., and Don R. LeDuc, Law of Mass Communication: Freedom and Control of Print and Broadcast Media, 7th ed. (Westbury, NY: The Foundation Press, Inc., 1992), p. 100.
15. Pember, Don R., Mass Media Law, 5th ed. (Dubuque, Iowa: William C. Brown Publishing Co., 1991), p. 232.

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16. Francois, William E., Mass Media Law and Regulation, 6th ed., (Dubuque, Iowa: Grid Publishing, 1994), p. 206.
17. Smolla, Rodney A., Law of Defamation, (New York, NY: Clark Boardman Co., Ltd.:1989), Ch 10, Sec. 10-04.
18. Gentile, p. 50.
19. Teeter, 7th ed., p. 250.
20. *Richmond Newspapers, Inc. v. Virginia*, 448 U.S. 555 (1980), op cit., Teeter, Dwight L., Jr., and Don R. LeDuc, Law of Mass Communication: Freedom and Control of Print and Broadcast Media, 7th ed. (Westbury, NY: The Foundation Press, Inc., 1992), p. 683.

"Chief Justice Warren Burger emphasized that of concern in [this case] was whether the First and Fourteenth Amendments guarantee a right of the public (including the press) to attend trials."

21. Altman, Lawrence K., "U.S. to Let States Set Rules on AIDS-Infected Health Care Workers," *N.Y. Times*, June 16, 1992 at C7.
22. AMA, Statement of HIV-infected Physicians (January 17, 1991).
23. Teeter, Dwight L., Jr. and Don R. LeDuc, Instruction Manual to accompany Law of Mass Communications, Freedom and Control of Broadcast of Media, 8th ed. (1995), p.7.

PART II
RESEARCH METHODOLOGY

This study is an interpretative examination of responses by some courts to a significant medical, ethical and social policy issue facing the health care industry and the legal community in the 1990s.

As the courts are framing the debate, it seems to be a matter of pitting the privacy of an individual health care provider against the patient's right to get information about the provider's HIV status. As suggested earlier, the clash in value systems is exacerbated by emotional fall-out from fear of and prejudice against HIV-positive individuals. Whose best interest is the most important? Is it the physician's right to protect what could be considered private information or is it the patient's right to be fully informed?

This thesis, then, describes and analyzes four illustrative court decisions in some detail, treating each decision as a case study of interrelated medical facts and privacy issues. In each case, the object is to isolate the "rule of law," detailing the reasoning by a court for deciding the case or controversy. These cases were chosen for this analysis for several reasons.

First, they best illustrate the primary controversy and, based on my survey of secondary literature, these are the cases most often cited. They are timely (1991-1995) and they illustrate the

great degree of consideration and deliberation the courts have placed on deciding cases that involve the HIV-status disclosure of physicians. Finally, these cases appear to represent significant patterns in the evolution of the courts' approaches to HIV-related privacy issues.

In addition, collateral information from various books, articles, public health policies adapted by the CDC, the American Medical Association (AMA) and others serve as the resources for the research of this study.

I will first present a thumbnail sketch of these cases that will provide a justification for their inclusion in this study. This next part, Part III, is the Literature Review, in which I present some of the most recently recorded data regarding the impact of the AIDS crisis worldwide. Subsequently, this thesis will address the privacy vs right-to-know dilemma with an historical overview of the evolution of privacy law. Part IV opens with a detailed outline of two cases that are unrelated to AIDS, but which have been repeatedly utilized by the courts in deciding AIDS-related cases. For this reason, they are of critical importance to this study. Following that is a discussion and analysis of the four pertinent AIDS-related cases as mentioned above. Concluding comments and evaluations are reserved for the final part, Part V.

Table 1.1 Illustrative Court Cases Examined

Court Case	Year	Prevalent Interest	Contingencies
United States v. Westinghouse Electric Corporation	1980	Government access to a company's employee medical records	Public health risk of contracting illness due to toxin exposure
School Board of Nassau County v. Arline	1987	A communicable disease defined under the Americans with Disabilities Act	Public health risk of communicating an infectious disease to others in the workplace
Estate of Behringer v. Medical Center at Princeton	1991	Patient HIV-status confidentiality and hospital's right to restrict surgical privileges for an HIV- positive physician	Breach of patient confidentiality and public health risk of communicating infectious disease to patients
In Re: Application of Milton S. Hershey Medical Center	1991	Hospital's right to suspend surgical privileges of an HIV- positive physician	Public health risk of communicating infectious disease to patients
Faya v. Almaraz	1993	Physician's obligation to disclose HIV-status and patient's right to collect monetary damages	Public health risk of communicating infectious disease to patients and potential for adverse economic impact on physician
John Doe v. University of Maryland Medical Systems Corporation	1995	Hospital's right to restrict surgical privileges of an HIV- positive physician	Public health risk of communicating infectious disease to patients

A THUMBNAIL SKETCH: FOUR ILLUSTRATIVE CASES

The first case I will sketch presented a sort of "double whammy" situation for a New Jersey hospital because the physician was employed there and was diagnosed as HIV-positive at that same facility. In the *Estate of Behringer v. Medical Center at Princeton*,¹ a New Jersey Court held that a hospital's policy of restricting an HIV-infected surgeon's staff privileges was substantially justified by a reasonable probability of harm to the patient.

In this same case, the court held that the plaintiff was entitled to damages because the hospital breached its duty of confidentiality to the plaintiff, as a patient, when it failed to take reasonable precautions regarding the physician plaintiff's medical records to prevent his AIDS diagnosis from becoming a matter of public knowledge.

In re Application of Milton S. Hershey Medical Center,² "Dr. Doe" voluntarily submitted to blood testing for the HIV virus after he was cut during an invasive operative procedure. After he tested HIV positive, Dr. Doe withdrew from participation in further surgical procedures. The issue was whether the trial court abused its discretion in finding that the hospital sustained its burden of

demonstrating "compelling need" for disclosure of Dr. Doe's HIV status. Only a "compelling need" permits disclosure under Pennsylvania's statute making HIV test results confidential.

Another case involving two separate issues of a physician's legal responsibility to disclose and a patient's right to collect monetary damages is evident in *Faya v. Almaraz*.³ In this 1993 case, an oncological surgeon, Dr. Almaraz, died from AIDS and two former patients sought compensation based on their fear of contracting the disease, alleging that Dr. Almaraz acted wrongfully by operating on them without first informing them that he was HIV-positive and/or suffering from AIDS. The plaintiffs further alleged that the hospital at which Dr. Almaraz practiced was liable for permitting Dr. Almaraz to do so.

A lower Maryland court dismissed the plaintiffs' complaints, concluding that they had not succeeded in proving an alleged compensable injury. They appealed the decision. The court of appeals reversed the lower court's decision, finding that it was foreseeable that Dr. Almaraz might transmit the AIDS virus to his patients during an invasive surgery.

In April 1995, a case similar to the *Hershey* case surfaced in Maryland. *Doe v. University of Maryland Medical System Corp.*⁴

involved a third-year neurosurgical resident at the University of Maryland Medical System (UMMSC). Dr. Doe sustained a needle stick while treating an individual who may have been infected with the HIV virus and subsequently tested positive for the AIDS virus and was suspended from surgery.

Dr. Doe contended that the risk of his transmitting the HIV virus to any of his patients is so infinitesimal he could not be considered a significant risk. The court disagreed.

Each of the four cases mentioned will be analyzed in terms of its facts, issues, decisions and reasoning. These decisions provide an early appraisal of developing rules of law--both tort law and constitutional law--on the issue of confidentiality for health care providers' HIV status.

In one sense, this is a study of how the explosion of the AIDS virus is causing an evolution in privacy law and, ultimately, in public policy. Lessons drawn from these cases will be used by the author as a professional in healthcare administration to suggest--tentatively--how a hospital might protect itself **and** the rights of its patients **and** health care providers within guidelines that may be drawn from these important decisions.

NOTES PART II

1. *Estate of Behringer v. Medical Center at Princeton*, 592 A.2d 1251, (N.J. Superior. Ct. Law Div.(1991).
2. *In re Application of Milton S. Hershey Medical Center*, 595 A.2d 1290 aff'd 634 A.2D 159 (Superior. Ct. Pa., 1991).
3. *Faya v. Almaraz*, 329 Md. 435, 620 A2d 327 (1993).
4. *Doe v. University of Maryland Medical System Corp.*, 50 F.3d 1261, (4th Cir. 1995)

PART III
A REVIEW OF THE LITERATURE

The numbers are staggering. The January 23, 1994 edition of *The New York Times* reported that The World Health Organization was estimating that by the year 2000, some 40 million people worldwide will have AIDS or will be infected with the Human Immunodeficiency Virus (HIV).¹ A *Public Health Reports* article published about the same time predicts that by the year 2000, approximately 82,000 children in the United States alone will be orphaned because of AIDS.² That article said that as of 1994, there were an estimated 500,000 cases of pediatric AIDS worldwide, and an estimated 10 million asymptomatic persons with HIV.³

It has been said that death is the ultimate price to pay. But, the cost doesn't stop there. The financial burden imposed by the AIDS epidemic is considerable. In 1993, the Centers for Disease Control and Prevention (CDC) reported more than 40 percent of its budget was dedicated to AIDS-related research.⁴ Statistics show that by 1990, the federal government had spent more than \$5.5 billion on HIV-related programs and the estimated lifetime medical care cost of treating a person with AIDS is approximately \$119,000 and rising.⁵

The reality of the devastation of AIDS has prompted public

health officials to propose various "solutions" in an effort to slow the spread of the disease, including discussions of mandatory testing. Even though the CDC views this measure as impractical, in 1991, it recommended adherence to "universal precautions." A 1992 article in the *Journal of the American Medical Association* detailed these guidelines:

1. Health care workers with lesions or weeping dermatitis should refrain from direct patient care and from handling patient care equipment or devices used in performing invasive procedures.
2. Health care workers should comply with current guidelines for disinfection and sterilization of reusable devices used in invasive procedures.
3. HIV and HBV-infected individuals should not be restricted from practicing invasive procedures provided that those procedures are not identified as "exposure-prone." (This met with heated debate and was amended as follows: State health departments should decide on a case-by-case basis whether HIV-positive health care workers pose a risk to their patients.
4. Health care workers who perform exposure-prone procedures should know their HIV status. "Exposure prone" includes digital palpitation of a needle tip in a body cavity or the simultaneous presence of

the health care worker's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site.

5. Health care workers who are HIV-positive should not perform exposure-prone procedures unless an expert review panel has advised them that they may continue to perform the procedures. An HIV-positive health care worker may be permitted to continue to perform invasive procedures pursuant to the expert panel's advice only if the prospective patients are notified of the health care worker's seropositivity before they undergo exposure-prone invasive procedures.
6. The CDC does not recommend mandatory testing of health care workers for the HIV antibody.⁶

A July 1992 article by the National Commission on AIDS said that the CDC guidelines met with harsh resistance from the medical/profession organizations because they essentially required patient consent prior to exposure-prone procedures and would therefore eliminate infected health care workers from performing such procedures.⁷ Certainly, in this situation an HIV-positive health care worker's anonymity could be compromised. This privacy issue is precisely the point of debate and a major force in the recent development of law.

Privacy, said to be one of the hottest issues in the 1990's, is loosely defined as "the right to be left alone."⁸ Of all the rights bestowed upon Americans by the Constitution, perhaps none is more revered than the right to privacy.

Even though privacy is not specifically defined by name within the Constitution,⁹ since 1960, the Supreme Court of the United States has recognized privacy as a constitutional right and held that a constitutional right to privacy is implied in the Fourth, Ninth, and Fourteenth amendments to the United States Constitution. Further, "many state constitutions contain express provisions protecting the right to privacy."¹⁰

Concern over the right to privacy, whether implied or absolute, did not originate with the beginning of time. In fact, it wasn't until the latter part of the nineteenth century that the right to privacy became an issue subject to debate and interpretation. It was in 1890 that two young Boston law partners decided to use the *Harvard Law Review* to write what has been regarded as "the fountain from which the modern law of privacy has flowed."¹¹

Apparently frustrated over the "carte-blanc" journalism of that era, which was comprised primarily of "insidious but well-organized gossipers in most small American communities [who]

stripped most residents of all but their deepest-held secrets,"¹² the law partners, Samuel D. Warren and Louis D. Brandeis, decided they had had enough. "Instantaneous photographs and newspaper enterprise have invaded the sacred precincts of private and domestic life; and numerous mechanical devices threaten to make good the prediction that 'what is whispered in the closet shall be proclaimed from the house-tops.'"¹³

The two were offended by gossip in the press, which they said had overstepped in every direction the obvious bounds of propriety and decency:

To satisfy a prurient taste the details of sexual relations are spread broadcast in the columns of the daily papers. To occupy the indolent, column upon column is filled with idle gossip, which can only be procured by intrusion upon the domestic circle. . . .

The common law has always recognized a man's house as his castle, impregnable, often, even to its own officers engaged in the execution of its commands. Shall the courts thus close the front entrance to constituted authority, and open wide the back door to idle or prurient curiosity?¹⁴

In essence, they wanted the courts to recognize a legal right

to privacy whereby citizens would have the option to seek and receive monetary damages in the event their privacy was intruded or violated.

But, they also realized there was a difference in "privacy" and "secrecy." While the two terms are different, they clearly overlap. As Sissela Bok wrote in her book Secrets: On The Ethics of Concealment and Revelation, secrecy and privacy overlap "most immediately in the private lives of individuals, where secrecy guards against unwanted access by others--against their coming too near, learning too much, observing too closely."¹⁵ Bok also infers that people can get "burned" by secrecy:

Secrecy is as indispensable to human beings as fire, and as greatly feared. Both enhance and protect life, yet both can stifle, lay waste, spread out of all control. Both may be used to guard intimacy or to invade it, to nurture or consume. And each can be turned against itself; barriers of secrecy are set up to guard against secret plots and surreptitious prying, just as fire is used to fight fire.¹⁶

In 1903, thirteen years after the publication of the Warren and Brandeis article, New York became the first state to recognize a law of privacy. Today the courts or legislatures in virtually all states

have recognized some kind of an enforceable law of privacy. It is important to note, however, that **recognition** of a law merely reinforces a legal conclusion or opinion without guaranteeing anything, including legal recourse and judgment of damages.

As if peering into the future, Warren and Brandeis wrote in their famous 1890 article:

That the individual shall have full protection in person and in property is a principle as old as the common law; but it has been found necessary from time to time to define anew the exact nature and extent of such protection.

Political, social, and economic changes entail the recognition of new rights, and the common law, in its eternal youth, grows to meet the demands of society. Thus, in very early times, the law gave a remedy only for physical interference with life and property, for trespasses *vi et armis*. [with force]

Then the "right to life" served only to protect the subject from battery in various forms; liberty meant freedom from actual restraint; and the right to property secured to the individual his lands and his cattle. Later there came a recognition of man's spiritual nature, of his feelings, of his intellect. . .

Gradually, the scope of these legal rights broadened; and now the right to life has come to mean the right to enjoy life--the right to be left alone; the right to liberty secures the exercise of extensive civil privileges; and the term "property" has grown to comprise every form of possession--intangible, as well as tangible.¹⁶

Brandeis, later recognized as one of the United States Supreme Court's greatest justices, wrote that the makers of the American Constitution "sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They [the Constitution's framers] conferred, as against the government, the right to be left alone--the most comprehensive of rights and the right most valued by civilized man."¹⁷ Despite Justice Brandeis' stirring words, written in *Olmstead v. United States* in 1928, there then was no recognized constitutional right of privacy.

Over the course of the past 100 years, through legislative and judicial efforts, pieces of the implied right to privacy have evolved into an expanding tort law of privacy. According to the late William L. Prosser, one of America's foremost tort scholars, there are four kinds of torts under the umbrella of privacy invasion:

- 1) Intrusion on a person's physical solitude, as by physical trespass or, for example, with a telephoto lens.
- 2) Publication of private matters (sometimes referred to as "private facts") violating the ordinary decencies.
- 3) Putting a person in a "false light," but not necessarily a defamatory light in the public's eye. (As Dean Prosser pointed out, this is the only category of privacy law where provable truth can serve as a defense.)
- 4) Appropriation, which means to use a person's name or likeness for advertising purposes without permission.¹⁸

Although specific fact situations can force two or more of the privacy subtypes paraphrased above to overlap, the main thrust of this thesis will center around number 2: "publication of private matters."

Professor Don Pember has termed private information the "most controversial aspect of the right to privacy in the current decade is that aspect of the law [that] penalizes the publication of private information about a person."¹⁹ John Zelezny, like the authors of several general communications law texts, says that perhaps one of the main reasons this is such a controversial aspect

of the right to privacy is because it "runs contrary to traditional American precepts about freedom of expression by allowing suits to be brought for the dissemination of truthful information."²⁰

This element distinguishes it from defamation, which involves injury to a person's reputation through the dissemination of **false** information. In a private facts privacy suit, the disclosed facts must be truly private. Here, "truth is no defense, rather it is part of the problem."²¹

What facts, then, are defined as private? This, too, may be one reason for the controversy in the area of privacy law, because the definition continues to evolve. In The Mass Media and The Law, John Watkins wrote that "there is considerable information that the average person considers 'private' and would not want discussed in public: sexual matters, details of one's physical or mental health, idiosyncratic or eccentric behavior, involvement in criminal activities, and poverty."²²

To further differentiate between a defamation suit and a private facts privacy suit, Watkins offers the following information: "Although truth is a defense in a defamation suit, it offers no protection in an invasion of privacy action of this type. With respect to defamation, the law of torts seeks to protect a person's

interest in his reputation, in his 'good name.' At least in theory, defamation is not concerned with the individual's humiliation or embarrassment."²³

The tort of invasion of privacy, as outlined in The Second Restatement of Torts, is concerned with precisely this type of injury:

One who gives publicity to a matter concerning the private life of another is subject to liability to the other for invasion of his privacy, if the matter published is of a kind that would be highly offensive to a reasonable person, and is not of legitimate public interest.²⁴

But, before the debate of whether one's HIV status can be characterized as a private fact, it is important to first touch on how the courts and others define "offensive," and "legitimate concern."

Certainly, there are varying definitions of what is considered offensive. What may offend one person may not offend another. As one text on privacy law states: "Because offensiveness is a jury question, what constitutes a highly offensive revelation may vary with communities and regions."²⁵

According to Funk and Wagnalls' *Standard College Dictionary*:

of.fen.sive *adj.* 1. Unpleasant or disagreeable to the senses; obnoxious; disgusting. 2. Causing anger, resentment, etc.²⁶

But, the question is not whether a plaintiff was merely embarrassed or experienced an unpleasant sensation by the disclosure of facts; rather the plaintiff must convince the court that disclosure of the information clearly overstepped the prevailing notions of decency. This is an important point, and further illustrates the fact that because "the norm" does not represent absolute consistency; because it does vary from place to place and person to person; because it does change and evolve, it is particularly difficult to adopt policy which sufficiently defines and addresses all aspects of the issue.

However, there are some general guidelines. For example, while some information is closely-guarded and secret, certain types of information do not meet the "highly offensive" test, shocking a reasonable person's sensibilities. Although there is no precise legal definition, information which has been regarded as offensive in

nature generally involves "sexual confidences, unusual or stigma-laden physical disorders, mental disorders, or extremely bizarre personal habits."²⁷

Articulating a definition of "legitimate public interest" has proven to be as clear as muddied water. Perhaps in an effort to clarify the determinants of what constitutes "legitimate public interest" the U.S. Court of Appeals for the Ninth Circuit offered the following guidelines in the 1975 case of *Virgil v. Time*:

In determining what is legitimate public interest, account must be taken of the customs and conventions of the community; and in the last analysis what is proper becomes a matter of the community mores.

The line is to be drawn when the publicity ceases to be the giving of information to which the public is entitled, and becomes a morbid and sensational prying into private lives for its own sake, with which a reasonable member of the public, with decent standards, would say that he had no concern.²⁸

In a rapidly changing world, trying to figure out what is "legitimate public interest" has little to do with traditional definitions. It is more concerned with concepts and balancing

community ideals with the type of information in contention. So, a fundamental question here might be whether the revelation of HIV-status information could be categorized as being of "legitimate public interest." It is not a hospital administrator, a physician, a publication, or a broadcasting station that will define what is of "legitimate public interest." That matter will be decided--however awkwardly, however contradictorily--by courts and legislatures as they continue to define the laws of privacy.

There appear to be valid arguments on both sides of this controversy. Earlier, I presented statistics that indicate a very small likelihood of a patient contracting the AIDS virus from a physician. But, "very small" is not "none at all." And, when the stakes are this high, it may be that **any** risk of transmission is too much risk.

On the other side of the debate is the potential economic and personal devastation that would likely be experienced by an individual should public knowledge of his or her HIV-positive status materialize. As the director of the emergency department at San Francisco General Hospital said:

You'd have to be a fool to be willing to
go to work in a busy trauma center--where
there's a real risk that you could be

infected by a patient--when you know that the minute you get infected, you'll become unemployable, you'll be fired, your name will be put in the papers, and then you'll probably be sued by the patients you previously took care of."²⁹

It could be a Catch-22 situation. Under the American Medical Association's guidelines, and the Americans with Disabilities Act (ADA), physicians cannot refuse treatment to patients with AIDS.³⁰ Thus, they expose themselves to the risk of contracting HIV from infected patients. But, if transmission of the virus from the patient to the physician does occur, they risk being restricted from performing further invasive procedures on the basis of risk to future patients.

For purposes of this thesis, a primary question to be addressed is whether HIV-status information can be categorized as a private fact. This area of privacy law--the public disclosure tort--has been called the "true" Warren-Brandeis tort. This tort is concerned with the publication of truthful, but private information of an embarrassing nature about an identifiable individual. Unlike defamation, which involves dissemination of false information that injures an individual's reputation, this tort involves the widespread

disclosure of truthful information which damages someone's reputation. Again, this tort is defined as publication of information that "(a) would be highly offensive to a reasonable person and (b) is not of legitimate concern to the public."³¹

As stated earlier, one of the biggest problems with HIV-status disclosure is the cloud of moral stigma that tends to hang, in varying degrees, over AIDS sufferers. Despite this, however, private facts claims will not prevail unless courts are convinced that the information does not warrant legitimate public interest.

I believe without reservation that this is where the true controversy lies. The newsworthiness defense is legal acknowledgement that the public has a right to know in some cases, even at the expense of an individual's privacy. The big difficulty, of course, is drawing that line in the sand between what is newsworthy and what is not. Like the definition of "offensive," which varies from community to community, so shall our perception and definition of newsworthiness.

In the following pages, it will become clear that from 1980 to 1995, a number of court decisions in the United States have been divided on their interpretation of the definition of legitimate public interest within the realm of private facts privacy. And, on

their opinion of whether the public has a need--or a right--to know the HIV status of their physician.

NOTES PART III

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11. Pember, Don R., Mass Media Law, 5th ed., (Dubuque, Iowa: William C. Brown, 1991.), p. 201.
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PART IV
DISCUSSION AND ANALYSIS: THE CASES

As the cliché says, what is past is prologue. That is true when considering the topic of this thesis because efforts by the courts to deal with new problems generally rely on precedents generated in deciding older--and supposedly similar--cases. Hence, the truism that courts move with adequate precedents if not with adequate grace.

This section begins by discussing two cases involving privacy of medical information cases unrelated to the AIDS epidemic. Because courts operate on a system of precedent--with earlier decisions used to guide the present when analogous factual situations and legal issues arise--earlier medical privacy decisions set some of the rules for current judicial efforts to wrestle with privacy issues surfacing in AIDS-related cases.

THE WESTINGHOUSE CASE (1980)

Long before there was an AIDS crisis, confidentiality of medical records was a matter of legal--and even constitutional--protection. One example of this was the 1980 case of *United States of America v. Westinghouse Electric Corporation*.¹

On February 28, 1978, the National Institute for Occupational Safety and Health (NIOSH), received a written request from an

officer of the International Union of Electric Workers to conduct a health hazard evaluation at the Tafford, Pennsylvania, plant of the Westinghouse Electric Corporation. The plant manufactured electric insulators by means of an epoxy molding process. Specifically, the complaint concerned the possibility that workers were being exposed to one of the chemical compounds (methyl ethyl ketone) used in the molding process. It was believed that overexposure was causing the workers to suffer allergic reactions. The Director of NIOSH subsequently ordered an investigation.

Two months later, on April 21, 1978, representatives of NIOSH performed a walk-through inspection. They determined that there was no apparent risk of overexposure to that particular compound. However, they did discover significant levels of Hexahydrophthalic (HHPA), another toxin. They suspected the "culprit" was this element, which induces asthmatic symptoms. But, they would not know for sure until they could gain access to the company's medical records of those employees who were consistently exposed to the HHPA. Westinghouse refused the NIOSH inspector's access to the records, stating the records were confidential and citing concerns over employees' privacy. It is important to note that the records at issue include reports of physical examinations given to

employees at the time they are hired.

Generally, the employment physical included a chest x-ray, a pulmonary function test, hearing and visual tests, a blood count, an examination by a medical doctor, and the employee's reported medical history. Employees exposed to possible toxins were examined annually, and the results of these examinations were included in their medical records.

In the interim, NIOSH investigators conducted some preliminary medical interviews and performed tests comparable to the ones in the pre-employment and annual examinations. Their findings included detectable levels of HHPA antibodies in 12 of the 28 employees tested. Further, they found decreased lung capacity in some, in comparison to national norms of people of the same age, sex, height and race. Even so, they could not determine for certain whether the workers had suffered unduly as a result of exposure to the HHPA without some historical medical information. They needed access to those medical records in order to evaluate possible trends or patterns.

So, again, representatives of NIOSH repeated their request in the form of an administrative subpoena (*duces tecum*), to gain access to the employees' medical records. Again, Westinghouse

refused. It did offer some conditions under which the company would consider granting the request:

- (1) If the employees provided "written informed consent" authorizing Westinghouse to supply the records; and,
- (2) If Westinghouse was "provided written assurance by the United States Government that the contents of these records not be disclosed to third parties."²

In the opinion of NIOSH, the issue was not negotiable. Thus, the NIOSH filed this action in the district court seeking an order to enforce its subpoena.

Did NIOSH have a right to access the company medical records of employees of Westinghouse when there is a reasonable suspicion that these individuals are being exposed to toxic levels of chemicals, or are these records protected by the physician-patient privilege?

The court decided that NIOSH did have the right to get access to the medical records of the Westinghouse employees who appeared to have been subject to overexposure to toxins. Further, these records are not protected by physician-patient privilege.

The court found that the subpoena met all requirements for enforcement of an administrative subpoena. These guidelines had been established in the 1950 case *United States v. Morton Salt Company* whereby an administrative subpoena was enforceable when:

- (1) the inquiry was made within the authority of the agency,
- (2) the demand for production must not be too indefinite, and
- (3) the information sought is reasonably relevant to the inquiry.³

The court rejected Westinghouse's claim that the information was protected from disclosure, holding that even if Westinghouse had asserted a physician-patient privilege it would have been to no avail because "In no physician-patient privilege exists as a matter of federal common law" ⁴ and Pennsylvania's physician-patient privilege applied only to material that would blacken the patient's reputation.

Citing substantial precedent,⁵ the appeals court in *Westinghouse* upheld an agency's authority to review medical

records needed in the public interest. In balancing privacy interests against an interest in disclosure, the court said:

The factors [that] should be considered in deciding whether an intrusion into an individual's privacy is justified are the type of record requested, the information it does or might contain, the potential for harm in any subsequent nonconsensual disclosure, the injury from disclosure to the relationship in which the record was generated, the adequacy of safeguards to prevent unauthorized disclosure, the degree of need for access, and whether there is an express statutory mandate, articulated public policy, or other recognizable public interest militating toward access.⁶

That list of considerations suggests that, in a case involving HIV-related information where the "potential for harm" to the individual is great, a court would evaluate the justification for the information with great care. Nevertheless, by analogy, it is clear that under the *Westinghouse* standard, the individual's right to control personal information regarding HIV status may be overcome by a sufficiently strong public interest in disclosure.

The court also found that *Westinghouse* had not

demonstrated that individually identifiable medical records would be improperly disclosed, and that NIOSH's procedures of safekeeping the records, of removing the names and addresses of the individuals in its compilation of published data provided sufficiently adequate assurance of non-disclosure.

Even though the court ruled in favor of NIOSH, thereby granting access of specific Westinghouse employees' medical records to NIOSH, it reinforced the idea of individual autonomy, which suggests that anyone should be entitled to make up their own mind. The court maintained that:

Each employee is entitled to make an individual judgment as to whether s/he regards the information [contained in the file] so sensitive that it outweighs that employee's interest in assisting NIOSH in a health hazard investigation that may benefit the employee.

We do not think it appropriate for Westinghouse to assert the claims of individual employees to privacy in particular documents. Each employee is uniquely capable of evaluating the degree of confidentiality which s/he attaches to discrete items of information in his or her file.⁷

So while the court upheld the administrative subpoena

initiated by NIOSH, allowing permission to obtain the medical records of certain employees, the court maintained that it is a right of the individual employees to make their own decision whether they wished the information (selected or all-inclusive) contained in their file to be disclosed to NIOSH.⁸

THE ARLINE CASE (1987)

Another case which is not an AIDS-related case, but which has been cited in other AIDS-related cases, is the 1987 case of the *School Board of Nassau County v. Arline*.⁹ This landmark case, decided by the United States Supreme Court, was packaged as an employment discrimination lawsuit and involved the question of whether an individual with tuberculosis could be classified as handicapped within the meaning and provisions of Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination against an "otherwise qualified individual."¹⁰

An elementary school teacher who suffered from acute tuberculosis sued the school board because she maintained she was dismissed from her teaching job on the basis of her illness. The school board contended that her dismissal was because of the

contagious nature of the disease.

From 1966 until 1979, Gene Arline taught elementary school in Nassau County, Florida. She was discharged in 1979 after suffering a third relapse of tuberculosis in two years. After she was denied relief in state administrative proceedings, she brought suit in federal court. According to Arline's medical records, she was hospitalized for tuberculosis in 1957. However, for the next twenty years, the disease was in remission. Then, in 1977, a culture revealed that tuberculosis was again active in her system. Subsequent cultures taken in March 1978 and November 1978 were also positive.

After both relapses in 1978, the school board suspended Arline for the remainder of the school year with pay. At the end of the 1978-1979 school year, the School Board held a hearing, after which it discharged Arline, "not because she had done anything wrong, but because of the continued reoccurrence of tuberculosis."¹²

The District Court held that even though Arline suffered a handicap, she was not, under the guidelines of the Rehabilitation Act Section 504 a "handicapped person." Further, the court said it "found it difficult . . . to conceive that Congress intended

contagious diseases to be included within the definition of a handicapped person."¹³ It further noted that "even if we did assume a person with a contagious disease could be deemed a handicapped person, Arline was not 'qualified' to teach elementary school."¹⁴

The Court of Appeals reversed the decision, holding that "persons with contagious diseases are within the coverage of section 504 and that Arline's condition falls "neatly within the statutory and regulatory framework" of the Act."¹⁵ However, Chief Justices Rehnquist and Scalia disagreed with the ruling:

The record in this case leaves no doubt that Arline was discharged because of the contagious nature of tuberculosis, and not because of any diminished physical or mental capabilities resulting from her condition.

Thus, in the language of Section 504, the central question here is whether discrimination on the basis of contagiousness constitutes discrimination "by reason of handicap."

These principles compel the conclusion that contagiousness is not a handicap under the meaning of Section 504. It is therefore clear that the protections of the Act do not extend to individuals such as Arline.¹⁶

Further, the *Arline* court stated that an individual with an infectious disease is not otherwise qualified under Section 504 of the Rehabilitation Act if he poses a significant risk of communicating an infectious disease to others...and reasonable accommodation will not eliminate that risk.

Thus, the Court articulated and set forth a "test" to be used as a guide in determining significant risk. Termed the "four-pronged test of *Arline*,"¹⁷ the following factors must be used in assessing significant risk:

- 1) the mode of transmission (how the disease is transmitted);
- 2) the duration of risk (how long the carrier is infectious);
- 3) the severity of risk (the potential risk of harm to third parties); and,
- 4) the probability that the disease will be transmitted.

Even though the *Arline* case did not involve the AIDS virus, it is critical to this thesis because it is being used by some courts as a decision-making model in cases centering around AIDS.

Thus, the *Arline* case established a precedent applying judicial reasoning to AIDS-related cases.

THE BEHRINGER CASE (1991)

One of those cases where the *Arline* analogy was used is the 1991 case of the *Estate of William Behringer, MD v. The Medical Center at Princeton*.¹⁸ This is a case that raises the issue of a hospital's obligation to protect the confidentiality of an AIDS diagnosis of a health care worker, as well as a hospital's right to regulate the surgical activities of an HIV-positive physician.

This case involved the conflict between an HIV-infected physician's right under anti-discrimination laws and the patient's "right to know" under the informed consent doctrine.

William Behringer, MD was a board-certified otolaryngology (ENT) surgeon who had developed a successful practice during his ten years in the Princeton area. He also had a practice in facial plastic surgery. He had served as an attending physician at the medical center since 1979 and had performed surgery there since 1981.

In June of 1987, he began feeling ill and treated himself for

"various symptoms."¹⁹ After he decided he was not making any improvement, he consulted a physician.

On June 16, 1987, at approximately 11 p.m. the plaintiff complained of difficult in breathing and, after calling the treating physician, was taken to the emergency room and was examined by a number of residents and then by the treating physician. Then, the treating physician secured consent from the plaintiff to perform a pulmonary consultation, blood testing (including an HIV determinant test) and a bronchoscopy. The plaintiff was admitted to the medical center that evening.

The next day the results of the pulmonary test confirmed the presence of substances that are indicators of AIDS. Later that same day, the treating physician informed the plaintiff that the HIV test was positive and that he had AIDS. The physician, a close friend of the plaintiff, told the plaintiff that he had told his wife, also a close friend of the plaintiff.

At this point, the plaintiff's presence as a patient in the medical center became of paramount concern and it was suggested that he be moved to another facility in order to protect his confidentiality. It was then determined that the best way to ensure confidentiality would be for the plaintiff to receive any

further care at home. Thus, to minimize the significance of his condition, the plaintiff walked out of the hospital rather than following the normal medical center policy of being wheeled out.²⁰

Over the next few days, the plaintiff received several telephone calls at home from colleagues and patients who obviously knew the plaintiff's medical condition was HIV-positive.

The medical center's reaction to the plaintiff's condition was swift. After medical center administrators learned of his condition, all upcoming surgery cases were canceled. However, after considerable research into the situation, the chairman of the department of surgery urged that the surgical privileges of the plaintiff be restored. An executive committee of physicians and administrators overruled that recommendation and Dr. Behringer's privileges remained revoked.

The hospital's administrator was concerned for the well-being of the patients, as well as for the medical center and its potential for liability. The board of trustees believed that the physician posed no harm to patients. Thus, subsequent meetings between the executive committee and administrators were held to research and debate the issue. During the ensuing months, "the medical

center embarked on a tortuous journey [that] shifted course as views were explored and, ultimately, a consensus reached between the medical staff, hospital administration and the board of trustees."²¹

Finally, in a special-called meeting of the medical staff, the executive committee voted to require the use of an "informed consent form" that would be presented to patients about to undergo surgery by HIV-positive surgeons. Further, it adopted a policy mandating that HIV-positive physicians would not be allowed to perform exposure-prone procedures, including surgical assisting.²²

Because knowledge of the physician's illness had become "common knowledge," once he did return to his office practice, cancellations of patient appointments became "the order of the day." His employees quit, not wanting to be associated with him. He died two years later in July, 1989.

As previously noted, the hospital took certain measures to keep the test results of Dr. Behringer confidential. Even so, the news of his positive HIV test result became widely known throughout the hospital and the community. Because of this, the opinion of the court was that the hospital breached its duty to

keep such records confidential and was liable for damages.

As to the issue of whether the hospital rightfully suspended the physician's surgical privileges, the court agreed with the hospital's action.

Using the four-pronged test of *Arline*, the court held that the hospital's policy of requiring informed consent of the patient was reasonable because of the fatal nature of the disease and that the hospital acted properly in initially suspending the physician's surgical privileges, subsequently imposing a requirement of informed consent, and eventually barring him from performing surgery. The court noted that experts concurred that there is at least some theoretical risk of probability of harm to patients, noting that "knowledgeable people differed" on the degree of risk of transmission from physicians to patients. The court also noted that "restricting a physician who posed any risk of transmission was proper when viewed in the context of informed consent."²³

The court contended that the "severity prong" of *Arline* outweighed the "probability prong" because it was based on a statistical assumption, noting:

There has been no scrutiny of transmission of HIV from physicians to patients, and there is no recorded case where it has occurred.

This is not surprising since there has been no systematic attempt to discover which physicians are HIV positive.

But, there has been careful examination of transmission from patient to health care worker, and some indication of the level of risk in both directions can be ascertained.

It is not possible to precisely quantify the chance of spread of HIV to a patient. In general terms, the probability is small but real.²⁴

The court also addressed the ethical component of this issue, saying that the physician and the patient were not in an equitable relationship and that the physician should be charged as the "more responsible" party:

The doctor is trained to recognize, diagnose, and avoid contracting the patient's disease. The doctor stands in a position of trust-a fiduciary position-in relation to the patient.

A small but palpable risk of transmitting a lethal disease to the patient gives the doctor an ethical responsibility to perform only those

procedures that pose no risk of transmission.

The patient, on the other hand, has no corresponding ethical duty to the doctor. The patient is neither trained nor expected to ascertain the provider's health status.²⁵

Finally, in conclusion, the court offered the following:

If there is to be an ultimate arbiter of whether the patient is to be treated invasively by an HIV-positive surgeon, the arbiter will be the fully-informed patient.

The ultimate risk to the patient is so absolute--so devastating--that it is untenable to argue against informed consent combined with a restriction on procedures which present 'any risk' to the patient.²⁶

THE HERSHEY MEDICAL CENTER CASE (1991)

A case involving a physician who challenged a medical center's decision to suspend his privileges upon learning of his HIV-positive status is the 1991 case of *In re Application of the Milton S. Hershey Medical Center*.²⁷

Dr. John Doe*, was a resident physician in obstetrics and gynecology who worked alternately between two Pennsylvania hospitals: the Milton S. Hershey Medical Center to the Pennsylvania State University ("Hershey Medical Center) and the Harrisburg Hospital.

On May 19, 1991, Dr. Doe was doing an invasive gynecological procedure and was accidentally cut by the attending physician. The record does not indicate whether there was an actual transfer of blood between Dr. Doe and the patient.

The following day, Dr. Doe voluntarily submitted to blood testing for the HIV virus. Two days later, on May 21, 1991, Dr. Doe was notified that the results were positive.* At that time, Dr. Doe voluntarily withdrew from performing any more invasive procedures. An additional test, called the Western Blot, was performed on Dr. Doe's blood. These results were returned on May 28, 1991 and confirmed that Dr. Doe was HIV positive. Dr. Doe then informed his employers and pursued a voluntary leave of absence.

*Note: The gender of Dr. Doe is not known. However, in compliance with traditional journalism guidelines, I will use the masculine pronoun, where necessary.

After investigation, Hershey Medical Center identified 279 patients who had been in contact with Dr. Doe since the time of his joint residency. This included every patient who could be identified as having any potential exposure to Dr.Doe's condition. Both Hershey Medical Center and Harrisburg Hospital filed petitions alleging there was a "compelling need" to disclose information regarding Dr. Doe's condition to the patients potentially affected by contact with him. The general term "compelling need" is defined in Pennsylvania's Confidentiality of HIV-Related Information Act and is based on the consideration of societal implications, commanding a balancing analysis:

In assessing compelling need . . . the court shall weigh the need for disclosure against the privacy interest of the individual and the public interests which may be harmed by disclosure.²⁸

*It is important to note here that while transmission of the HIV virus does occur immediately upon exposure to contaminated body fluids, the presence of HIV antibodies is not immediately detectable, or even detectable within days of exposure. Thus, Dr. Doe was HIV-positive **before** being accidentally cut during surgery.

Further, the court stated that in determining whether there is a compelling need for testing, the need for disclosure must be measured against not only the privacy interest of the individual, but also the general public interests that will be harmed by breach of privacy or involuntary testing. In accord with general law on testing, and the specific intention of the legislature to encourage voluntary testing, a "compelling need" should be understood to be a concrete medical need. A mere desire to know should not be enough. Instead, the person seeking the test must require the result in order to make an important medical decision.²⁹

It is important to mention that, as a measure of defense against hot criticism from Pennsylvania's American Civil Liberties Union, the *Hershey* court criticized the ACLU's contention that there is little difference between secrecy and privacy and the intent of the Act was to condone a high level of secrecy:

Secrecy in its purest form exacerbates fear and aggravates misconceptions. The Act allows for confidentiality in testing, but includes limited exceptions when a compelling need for the release of certain information is demonstrated.³⁰

Further, they argued that disclosure of Dr. Doe's identity was necessary to prevent the spread of the disease. They also believed that limited disclosure was necessary to protect other health professionals from stigma and to alleviate any "mass hysteria" that could result from a general disclosure. Finally, the hospitals contended it was their duty to inform the possibly affected individuals of their potential exposure to the HIV virus.

Understandably, Dr. Doe disagreed. He asserted his right to privacy and argued that a compelling need did not exist that would warrant the disclosure of his HIV-related information. His lawsuit framed the issue this way:

Did the lower court exercise appropriate authority and discretion in allowing the selective disclosure of HIV-information of Dr. John Doe? Could the hospitals uphold their burden of proving "compelling need?"

Taking into account the infectious nature of the virus, the devastating outcome of full-blown AIDS and the recent pronouncements of the American Medical Association and American Dental Association that doctors who test HIV positive have an ethical obligation to refrain from professional activity that has an identifiable risk of transmission, the court found that the hospital

demonstrated an adequate "compelling need" for disclosure.

The court held that the lower court acted appropriately and within its authority and that the hospitals sustained their burden of proving "compelling need." The court ruled that "a hospital [that] invites the sick and infirmed, impliedly assures its patients that they will receive safe and adequate medical care."³¹

Given the nature of Dr. Doe's profession, the demands of his work, the facts of this case, the need for disclosure, the harm that could result from disclosure and Dr. Doe's privacy interest, the superior court found that selective disclosure was appropriate. Further, the court said:

AIDS is not a disease that is, or that should be, taken lightly. Rather, many view it as a problem of epidemic proportion that knows no bounds and discriminates against no one. Although HIV has been extensively researched, the public, justifiably or not, is wary and frightened of its prevalence in our society.³²

The court also was sensitive to the balancing interests apparent in this issue. It held that public policy must be based and formulated on scientific knowledge and not on public perception

or fear. Still, in this case, the public's right to be informed outweighed the physician's right to total privacy. The Court noted:

Privacy rights are of paramount importance in this Commonwealth. But the public's right to be informed in this sort of potential health catastrophe is compelling and far outweighs a practicing surgeon's right to keep information regarding his disease confidential.³³

The Court viewed the actions taken by the medical center as responsible, and concurred with the decision of the lower court. Further, the medical center was able to protect the patients by notifying them by letter that they may have been exposed to the AIDS virus through services rendered at their facility. But, the physician's identity also was protected. Remember, the medical center never did divulge the name of the physician to the patients in the letters, although it is evident that his HIV status was known through word-of-mouth among doctors, nurses, and at least some patients.

One final note: None of the patients who were contacted regarding their potential exposure to Dr. Doe tested positive for the HIV virus.

On appeal, the decision was affirmed.

As a practical matter, though, courts recognize the intensely personal and sensitive nature of HIV-related information. As the federal district court stated in *Doe v. Coughlin*:

There are few matters of a more personal nature, and there are few decisions over which a person could have a greater desire to exercise control, than the manner in which he reveals [an AIDS] diagnosis to others.

Given the most publicized aspect of the AIDS disease, that it is related more closely than most diseases to sexual activity and intravenous drug use, it is difficult to argue that information about this disease is not information of the most personal kind, or that an individual would not have an interest in protecting the dissemination of such information.³⁴

THE *FAYA V. ALMARAZ* CASE (1993)

At about the time the *Behringer* case was being decided in New Jersey, a similar fact situation case was unfolding in Maryland. In *Faya v. Almaraz*, a Maryland court held that an oncological surgeon was negligent in failing to notify his patients that he was

HIV-positive prior to performing their surgeries, even though after surgery, the patients tested negative for the virus.³⁵

Dr. Rudolph Almaraz had known he was HIV positive since 1986. An oncological surgeon specializing in breast cancer with operating privileges at the Johns Hopkins Hospital (Hopkins) in Baltimore, Dr. Almaraz kept his condition a secret. (It is not apparent whether the hospital knew of his condition.)

On October 7, 1988, Almaraz performed a partial mastectomy on Sonja Faya at Hopkins. He also removed some cancerous tissue from her the following March. On November 19, 1989, again at Hopkins, Almaraz surgically removed a benign lump from the breast of Perry Mahoney Rossi.

Between the second procedure on Faya and the surgery on Rossi, Almaraz was diagnosed with full-blown AIDS. Thus, not only did he know of his HIV status the entire period during which he performed surgery on the two women, he was diagnosed as having full-blown AIDS prior to the surgery on Rossi.

Almaraz subsequently gave up the practice of medicine in March, 1990, terminating his association with Hopkins in June of that year. He died of AIDS on November 16, 1990. Faya and Rossi learned of their physician's illness for the first time from a local

newspaper on or about December 6, 1990, well over a year after Rossi's operation and twenty months after Faya's last contact with Almaraz. Both women immediately underwent blood tests for the AIDS virus. Both women tested negative.

Nevertheless, on December 11, *Faya v. Almaraz* was filed in the Circuit Court in Baltimore City. In separate actions filed by both women, they alleged multiple counts of wrongdoing by Dr. Almaraz. Common to both complaints were counts alleging negligence, negligent failure to obtain informed consent, fraud and intentional infliction of emotional distress.

The gist of their complaints was that Almaraz acted wrongfully in operating on the women without first telling them he was HIV-positive and that Hopkins was culpable for allowing him to do so. The women alleged that the hospital failed independently to take steps, such as the suspension of Dr. Almaraz's surgical privileges, to prevent him from operating on unsuspecting patients, or to adequately obtain informed consent from such patients. They further imputed to Hopkins' vicarious liability for Almaraz's conduct, alleging that the physician acted as the hospital's agent or employee.

The plaintiffs in this case maintained that they incurred

injuries in the form of potential exposure to HIV and the risk of AIDS, physical injury and financial cost resulting from blood testing for HIV antibodies, and for intentional infliction of emotional distress that included "fear, pain, anxiety, grief, nervous shock, severe mental distress, headaches and sleeplessness."³⁶

The representatives of Dr. Almaraz stated that the physician owed no duty to disclose his ailment as part of the doctor-patient exchange leading to informed consent. Hopkins contended that it had no duty to investigate and to ascertain Almaraz's HIV status, adding that the obligations imposed by the informed consent doctrine did not extend to it in any case.

The trial court dismissed the women's complaints in their entirety. Judge Kaplan's reasoning basically implied that because there was no official documentation of such transmission, that it could not have happened:

Because there are no reported cases of transmission of AIDS from a surgeon to a patient, such transmission is only a theoretical possibility when proper barrier techniques are employed....

Plaintiff[s] [have] not alleged that Dr. Almaraz failed to use proper barrier techniques. Furthermore, the

plaintiffs [have] not alleged that any incident occurred during surgery that would have caused Dr. Almaraz's blood to enter [their bodies]."³⁷

The trial court also found that plaintiffs had failed to sufficiently allege exposure to HIV because they had not alleged that Dr. Almaraz had failed to use proper precautions or that any incident occurred during their surgical procedures that would have exposed them to HIV. Furthermore, both plaintiffs had tested negative for HIV more than six months after surgery. The lower court found that the plaintiffs' fear that "something that did not happen could have happened" was not an actionable injury.³⁸

Judge Kaplan's decision--however accurate in his depiction of the physical risk the women had encountered--nevertheless did not take sufficient account of the outrage caused by **any** kind of exposure to AIDS.

The women subsequently appealed the decision by the court to the Court of Special Appeals, asserting that a physician's duty of care requires an HIV-positive surgeon to disclose his HIV status and the risk of transmission of the AIDS virus during surgery, however minimal the risk, and that, therefore, Dr. Almaraz was negligent in

failing to disclose his HIV-positive status before operating on the plaintiffs.. The Court of Appeals overturned the decision of the lower court, stating:

While the appellants allege many counts of misconduct by the appellees, the core of their complaints is that Dr. Almaraz was negligent in failing to disclose his HIV-positive status before operating on Faya and Rossi.

Appellants assert that a physician's duty of care must encompass disclosure that an operating surgeon's HIV-positive status poses the risk, however minimal, of transmission of the AIDS virus during surgery.

We agree.³⁹

The Court also held that the concept of legal duty emanates from the "responsibility each of us bears to exercise due care to avoid unreasonable risks of harm to others."⁴⁰ It cited an earlier case involving infectious disease notification. In *B.N. v. K.K.*,⁴¹ a nurse alleged that a doctor with whom she had been intimate did not inform her of his genital herpes:

We began with the premise that an important factor used to determine the existence of duty is foreseeability. We then observed that one who knows that he or she has a highly contagious disease can readily foresee the danger that the disease may be communicated to others with whom the infected person comes into contact.

Because of this foreseeability, we held that the doctor has a legal duty to either refrain from sexual contact with others, or to inform his sexual partners of his disease.

Thus, the same principle applies in this case. Under the allegations of the appellants' complaints, it was foreseeable that Dr. Almaraz might transmit the AIDS virus to his patients during invasive procedures. Thus, we are unable to say, as a matter of law, that Dr. Almaraz owed no duty to the appellants either to refrain from performing the surgery or to warn them of his condition.

This is so even though the medical literature indicates that, with proper barrier techniques, the risk of HIV transmission during surgery is extremely low, for legal scholars have long agreed that the *seriousness* of potential harm, as well as its probability, contributes to a duty to prevent it.

While it may be unlikely that an infected doctor will transmit the AIDS virus to a patient during surgery, the patient will almost surely die if the virus is transmitted."⁴²

The court also said that "A physician's duty of care requires an HIV-positive surgeon to disclose his HIV status and. . .it was foreseeable that Dr. Almaraz might transmit the AIDS virus to his patients during an invasive surgery."⁴³ Further, the court reasoned that although the risk of transmission during surgery is extremely low, the seriousness of the potential harm, as well as its probability, contributes to a duty to prevent it."⁴⁴

The court also held that the plaintiffs could recover for their fear and any physical manifestations of such fear, but only between the time they learned of Dr. Almaraz's illness and the time they received their negative HIV test results.

Finally, the court held that a hospital is liable for the negligence of its employees and agents. Since the plaintiffs had alleged that Dr. Almaraz was the agent of the hospital and they had relied on this belief and the excellent reputation of the hospital in selecting Dr. Almaraz, the court concluded that these facts were sufficient to aver an agency relationship and that, therefore, the trial court should not have dismissed the complaints against the hospital.

THE UNIVERSITY OF MARYLAND MEDICAL SYSTEM CORP. CASE (1995)

In April 1995, nearly a decade after the *Arline* case, the U.S. Court of Appeals for the Fourth Circuit cited the *Arline* decision and applied the four-prong test in rendering an opinion in another case: *Doe v. University of Maryland Medical System Corp.*⁴⁵

Dr. Doe was a third-year neurosurgical resident at the University of Maryland Medical System (UMMSC). In January, 1992, Dr. Doe sustained a needle stick while treating an individual who may have been infected with the HIV virus. However, it is not known for certain if Dr. Doe was already infected with the virus prior to the needle stick. Dr. Doe subsequently tested positive for the AIDS virus. Upon learning of his HIV status, UMMSC suspended him from surgery pending a recommendation of its panel of experts on blood-borne pathogens. The panel recommended that Dr. Doe be allowed to return to surgical practice with the exception of certain specific procedures. In addition, the panel suggested that Dr. Doe be required to follow infection procedures and that if his blood ever contacted a patient's non-intact skin, he be required to notify his supervisor and the patient. He also would be required to provide a specimen of blood so that in the event a patient claimed

to have contracted HIV from Dr. Doe, the DNA of the two samples could be compared.

Following further review and careful consideration, senior administrators at UMMSC rejected the recommendations of the panel. They opted to permanently suspend Dr. Doe from surgical practice and offered him alternative residencies in non-surgical fields. After Dr. Doe refused the alternative residencies and insisted that he be reinstated with full surgical privileges, UMMSC terminated him from its residency program. They argued that he posed a significant risk because:

- 1) HIV may be transmitted via blood-to-blood contact in a surgical setting.
- 2) Dr. Doe always will be infectious.
- 3) Infection with HIV is fatal.
- 4) There is a degree of risk that Dr. Doe could transmit the virus during the course of his neurosurgical residency.⁴⁶

Further, UMMSC contended that the risk of injury from needles and other sharp instruments cannot be eliminated through reasonable accommodation; therefore, neither can the risk of

infection. Medical Center officials believed that the catastrophic effects of infection (3rd prong of *Arline*) with HIV combined with a minimal, but nevertheless ascertainable risk of transmission (4th prong of *Arline*) formed a sufficient basis upon which to conclude that Dr. Doe should not be allowed to continue his residency in neurosurgery.⁴⁷

Dr. Doe countered that the risk of him transmitting the HIV virus to any of his patients is so infinitesimal he could not be considered a significant risk.

The Court disagreed, holding that Dr. Doe indeed did pose a significant risk to the health and safety of his patients that cannot be eliminated through reasonable accommodation. It cited the U.S. Supreme Court's decision in *Arline* and reasoned:

The *Arline* Court stated that an individual with an infectious disease is not otherwise qualified under Section 504 of the Rehabilitation Act if he poses a "significant risk of communicating an infectious disease to others . . . and reasonable accommodation will not eliminate that risk."

Thus, the *Arline* factors "discount the severity of anticipated harms by the statistical probability that they will occur."⁴⁸

Further, the court stated that even though there may be no documented case of surgeon-to-patient transmission, (a statistical assumption) such transmission clearly is possible. Further, the risk of percutaneous [needle stick] injury can never be eliminated through reasonable accommodation because to do so would eliminate essential functions of employment.⁴⁹ Thus, even if Dr. Doe took extra precautions, some measure of risk would always exist because of the type of activities in which Dr. Doe would be engaged.

The Court held that UMMSC's decision to terminate Dr. Doe was thoroughly deliberated and in spite of the low risk of transmission, decided to err on the side of caution in protecting its patients.

Even though these decisions do not present definitive solutions to the dilemma of whether physicians should reveal their HIV status to their patients, they do address the controversy. Also, they illustrate the great degree of consideration and deliberation the courts have placed on deciding cases which involve the HIV-status disclosure of physicians, thus representing significant patterns in the evolution of the courts' approaches to HIV-related privacy issues.

In the final chapter, an effort will be made to draw from

these lessons in hopes of providing some insight for hospital administrators. Like it or not, when it comes to physician privacy issues and HIV status, it is the courts who are writing the textbooks and hospital policy manuals.

Table 2.1 Illustrative Court Cases with Decisions Rendered

Court Case	Year	Prevalent Interest	Contingencies	Court Decision
United States v. Westinghouse Electric Corporation	1980	Government access to a company's employee medical records	Public risk of contracting illness due to toxin exposure	Public's interest outweighed privacy interests
School Board of Nassau County v. Arline	1987	A communicable disease defined under the Americans with Disabilities Act	Public risk of contracting infectious disease by others in the workplace	Contagiousness not handicap under ADA.
Estate of Behringer v. Medical Center at Princeton	1991	Patient confidentiality and hospital's duty/right to restrict surgical privileges of HIV-positive physician	Breach of patient confidentiality; Public health risk of exposing patients to an infectious disease	Hospital breached confidentiality; OK to restrict privileges of HIV- positive physician
In Re: Application of Milton S. Hershey Medical Center	1991	Hospital's duty/right to suspend surgical privileges of HIV- positive physician	Public health risk of communicating infectious disease to patients	"Compelling need" to disclose HIV status
Faya v. Almaraz	1993	Physician's obligation to disclose HIV-status; patient's right to collect monetary damages for emotional distress	Public health risk of communicating infectious disease to patients and potential for adverse economic impact on physician	Damages awarded for emotional distress; Hospital liable for negligence of employees.
John Doe v. University of Maryland Medical Systems Corporation	1995	Hospital's right to restrict surgical privileges of an HIV- positive physician	Public health risk of communicating infectious disease to patients	HIV-positive physician poses "significant risk."

NOTES PART IV

1. *United States v. Westinghouse Electric Corp.* (638 F.2d 570 [1980]).
2. *Ibid.*, 573.
3. *United States v. Morton Salt*, 338 U.S. 632, 652, 70 S.Ct, 357, 368, 94 L.Ed. 401 (1950).
4. *Westinghouse*, 573.
5. [(*Whalen v. Roe*, 429 U.S. 589, 97 S. Ct. 869, 51 L.Ed.2d 64 (1977), and *E.I. duPont de NeMours & Co. v. Finklea*, 442 F. Supp. 821 (S.D.W.Va.1977)]
6. *Westinghouse*, 578.
7. *Ibid.*, 573.
8. *Ibid.*
9. *School Board of Nassau County v. Arline*, 480 U.S. 273, 107 S. Ct. 1123, 94 L.Ed. 2d 307, (1987).
10. Rehabilitation Act of 1973 (29 USCS Section 794)
11. *Arline*, 314.
12. *Ibid.*
13. *Ibid.*
14. *Ibid.*
15. *Ibid.*
16. *Ibid.*, 314.
17. *Ibid.*, 310.

NOTES PART IV (cont.)

18. *Estate of William Behringer, MD v. The Medical Center at Princeton*, 592 A.2d 1251 (N.J. Super.L. 1991).
19. Ibid., 1255.
20. Ibid., 1256.
21. Ibid., 1257.
22. Ibid., 1258.
23. Ibid., 1280.
24. Ibid., 1279.
25. Ibid., 1278.
26. Ibid., 1283.
27. *In Re Application of the Milton S. Hershey Medical Center of the Pennsylvania State University v. John Doe, MD.*, 634 A2d 159 (Pa. 1993).
28. 35 P.S. Section 7608 (C).
29. *Hershey*, 1295.
30. Ibid., 1297.
31. Ibid.
32. Ibid., 1301.
33. Ibid., 1302.
34. *Doe v. Coughlin*, [697 F. Supp. 1234, (1988)].

NOTES PART IV (cont.)

35. *Faya v. Almaraz*, [329 Md. 435, 620 A2d 327 (1993)].

36. *Ibid.*, 334.

37. *Ibid.*, 330.

38. *Ibid.*

39. *Ibid.*, 333.

40. *Ibid.*

41. *B.N. v. K.K.*, 312 Md. at 141, 538 A.2d 1175.

42. *Faya v. Almaraz*, 333.

43. *Ibid.*, 334.

44. *Ibid.*

45. *Doe v. University of Maryland Medical System Corp.*, 50 F.3d 1261, (4th Cir. 1995).

46. *Ibid.*, 1265.

47. *Ibid.*

48. *Ibid.*

49. *Ibid.*

PART V
CONCLUDING COMMENTS

Based on the decisions rendered in the cases presented, it is evident that the controversy over physicians' duty to disclose their HIV status is a delicate balance between the public's right or need to know and a physician's right to privacy. But within the confines of this issue are other considerations, too.

True, the controversy is established as a "privacy" issue. But, as illustrated, courts have placed heavy emphasis on deciding in favor of the legitimate public interest. For example, it is clear that under the *Westinghouse* standard, the individual's right to control disclosure of personal information regarding HIV status could be overcome by a sufficiently strong public interest in disclosure.¹

The *Arline* court established the "four-pronged test of Arline" to define significant risk, thus establishing a model of comparison for determining the risk of transmitting an infectious disease to the public.² Although the four cases examined for this study represent only a sample of the cases available, these cases--which have been widely publicized and discussed--placed priority on the "severity" prong, deciding in favor of the public's interest of being informed about potential hazards.

As mentioned previously, the *Arline* case centered around tuberculosis. The following is illustrative of how the Arline test

might be applied in relation to an AIDS case:

Prong 1: The mode of transmission:

It is a fact that AIDS is transmitted through intravenous drug-use, blood-to-blood or blood-to-other bodily fluids contact, and/ or unprotected sexual intercourse with one or multiple partners.

Prong 2: The duration of risk:

The CDC estimates that an individual can be the carrier of the HIV virus for up to ten (10) years.

Prong 3: The severity of risk:

Because AIDS is fatal, the severity of risk is absolute: 100%. This means that an individual who becomes infected through exposure to the HIV virus pays the ultimate price: their life.

Prong 4: The probability of transmission:

The probability of risk for transmission by an HIV-positive physician to a patient as estimated by the CDC is 1 in 42,000.

My question here is which prong is weighted most heavily? The first two prongs are not primary points of contention for the purposes of this discussion. But, look at the last two. Does the severity of risk carry more clout in determining significant risk than does the risk of transmission?

I would propose that since the fourth prong--probability of risk of transmission--is based on a statistical assumption, subject to a degree of error, and the third prong--severity of risk--is based on fact, it would seem reasonable that because death is **always** the outcome for the sufferers of the AIDS virus, the severity of risk would prevail over the possibility of transmission. Further, referring back to the reasoning by the *Behringer* court, there is no way possible to quantify the probability of risk from health care worker:

There has been no scrutiny of transmission of HIV from physicians to patients, and there is no recorded case where it has occurred. This is not surprising since there has been no systematic attempt to discover which physicians are HIV positive.

But, there has been careful examination of transmission from patient to health care worker, and some indication of the level of risk in both directions can be ascertained.

It is not possible to precisely quantify the chance of spread of HIV to a patient. In general terms, the probability is small but real.³

And, if it is correct to place more emphasis on the severity of risk, a similar parallel might be made if HIV-status information of health care professionals were ever to be considered as private fact and protected under privacy law. Could it be that when the statistical assumption, i.e., the probability of risk, is weighted against the reality of death, even then the weight of a private fact could be deemed inferior to the severity of risk? It is apparent that the decisions of the courts here leaned that way.

The *Behringer* court reasoned by analogy consistent with the *Arline* court. Not only did the *Behringer* case represent a court's effort to articulate the public's best interest, it also addressed the ethical obligation of physicians to reveal their HIV status. Here, the court held that the physician and the patient were not in an equitable relationship and that the physician should be considered the "more responsible" party.⁴

Then, shifting its attention to the public's best interest, the *Behringer* court noted that if anyone were to decide whether a

patient would submit to treatment by an HIV-positive surgeon, that "anyone" would be the fully-informed patient. This concept of individual autonomy is the idea that individuals are entitled to a degree of informed self-determination in making decisions concerning their own well-being. Hence, informed consent.⁵

Historically, a physician's disclosure of information should provide the patient with enough information about the risks inherent to treatment to allow a determination of whether to submit to proposed treatment. In the last twenty years, some courts . . ."have subscribed to the principle that the doctor's duty to the patient extends to the disclosure of all risks potentially affecting the patient's choice to submit to care."⁶

But, informed consent may be a double-edged sword when it involves a positive HIV-status because the ADA prohibits discrimination against anyone who falls into this category.⁷

Additionally, the American Medical Association (AMA) has stated physicians have a duty to treat all patients:

A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV. Persons who are

seropositive should not be subjected to discrimination based on fear or prejudice.

When physicians are unable to provide the services required by an HIV-infected patient, they should make appropriate referrals to those physicians or facilities equipped to provide such services.

A physician who knows that he or she is seropositive should not engage in any activity that creates a risk of transmission of the disease to others. A physician who has HIV disease or who is seropositive should consult colleagues as to which activities the physician can pursue without creating risk to patients.⁸

The AMA policy further states that physicians should disclose their health status to their patients before performing a procedure that poses an "identifiable risk of transmission" and proceed only if there is full informed consent or abstain from performing such procedures.⁹ In addition, the AMA encourages all physicians who perform surgery or other invasive procedures to be tested for the virus.

It would appear, then, that the informed consent approach, combined with the limitations imposed by the ADA and suggested by the AMA, backs physicians into a corner. Under these guidelines, physicians cannot refuse treatment to patients with AIDS, thus

exposing themselves to the risk of contracting HIV from infected patients during the performance of exposure-prone procedures. However, if transmission of the virus from the patient to the physician (thus, occupational transmission) does occur, they are restricted from doing further invasive procedures on the basis of risk to future patients. Nevertheless, the guidelines and policies outlined here support responsible behavior and a degree of disclosure.

With the *Hershey* case came the struggle of a hospital's administrator to do what was in the best interest of the public **and** an HIV-positive physician. (It is important to remember that Dr. Doe's name never was released to the public. In letters sent to patients of the hospital, the patients were informed that a resident physician who participated in their surgical procedure or obstetrical care was HIV-positive.) The administrator also realized this situation posed a potential legal quagmire because of the potential liability of one of the physician's patients becoming HIV-positive and the reality of that transmission being linked to the hospital.¹⁰

Because the court concurred with the medical center's decision to err on the side of caution in order to protect its patients, in essence, it acted out of legitimate concern for the

public without the physician's name being released.

Thus, the "legitimate concern" criterion of a private fact case would have been satisfied. To reiterate the definition suggested by the court in *Virgil v. Time*:

In determining what is legitimate public interest, account must be taken of the customs and conventions of the community; and in the last analysis what is proper becomes a matter of the community mores.

The line is to be drawn when the publicity ceases to be the giving of information to which the public is entitled, and becomes a morbid and sensational prying into private lives for its own sake, with which a reasonable member of the public, with decent standards, would say that he had no concern.¹¹

The other criterion for protection under privacy law is that to be actionable, the revelation of the truthful information must be highly offensive or shocking to a reasonable person.

I would contend that any reasonable person would be more offended by learning of their physician's positive HIV status **after** submitting to treatment that could endanger his or her life than learning of it **before** the treatment. Remember the two plaintiffs

in the *Faya v Almaraz* case? They asserted persuasively that they suffered from "pain, fear, anxiety, nervous shock, severe emotional distress, and headaches"¹² as a result of learning of Dr. Almaraz's HIV-positive status **after** he had performed surgery on them.

I would argue further that because AIDS has been part of our society now for more than two decades, the moral stigma attached to it has begun to give way to the desire to be informed about the disease.

The lower court in the *Faya v. Almaraz* case did not address the public's interest, concentrating instead on physician privacy. Judge Kaplan placed emphasis on the small probability of transmission instead of the severity of risk. Recall that this was in direct contrast to the *Behringer* court, which directly linked the degree of probability to the nonexistence of quantitative systems in place for statistical compilation of this data.

Judge Kaplan's decision promptly was overturned by the Maryland Court of Special Appeals. Citing an earlier precedent, the court held that each of us bears the responsibility to exercise due care to avoid unreasonable risks of harm to others.¹³ Although the terms "due care" and "unreasonable risks," are subjective with varying degrees of definition, clearly this court was unwavering in

its interpretation.

Further, although, the court acknowledged the relatively low risk of transmission of the HIV virus from a surgeon to a patient, it gave higher priority to the undisputable fact that the outcome of the disease is particularly devastating. Hence, the severity of the disease outweighed the low probability of transmission. And, again, the prevailing court decision centered on the overall best interest of the public, holding that the physician's positive HIV-status was of legitimate public interest.

The 1995 *Doe v. University of Maryland* case evidenced another hospital's attempts to formulate guidelines in confronting the issue of what actions, if any, were necessary in light of a physician's positive HIV-status. Upon learning of Dr. Doe's HIV-positive status, the initial plan by the hospital was to require Dr. Doe to follow infection control procedures and if his blood ever contacted a patient's non-intact skin, he be required to notify his supervisor and the patient.¹⁴

There is a glaring fallacy in this approach because notifying the patient **after** the infected blood has made contact with "non-intact" skin is "too little too late."

What the hospital did do was to, in effect, articulate its own

four-pronged test, which, incidentally, was generally consistent with the one in the *Arline* case. It said that Dr. Doe posed a significant risk because:

- 1) HIV may be transmitted via blood-to-blood contact in a surgical setting.
- 2) Dr. Doe always will be infectious.
- 3) Infection with HIV is fatal.
- 4) There is a degree of risk that Dr. Doe could transmit the virus during the course of his neurosurgical residency.¹⁵

Further, UMMSC contended that the risk of injury from needles and other sharp instruments cannot be eliminated through reasonable accommodation; therefore, neither can the risk of infection. Again, it was the severity of the risk that prevailed over the other factors.

Whether the *Arline* test will prove to be the dominant template in rendering decisions in AIDS-related cases is not known. Certainly, it is expected that there will be those who will criticize it. But, over the past decade, it has become an established precedent, being cited or referred to in one form or another in numerous

AIDS-related cases.

Even so, I propose that the truly burning issue here is not the usefulness of the *Arline* analogy, nor is it the ongoing tug-of-war between a physician's right to privacy and the patient's right to know, nor is it a discrimination issue or a financial issue. It is not even a medical issue. I agree that these are controversial issues, but do these issues represent the **real** controversy? I believe not.

I propose that the real issue here is not a legal one at all. It should **not** be a question of "what is legal?" It **should** be a question of "what is right?" In the age of sophisticated, gray-area law formulation, I fear that society has strayed from the fundamentals of accountability, misplacing emphasis on claims of individual rights and not concentrating on right and wrong. It seems to be in vogue to be able to skirt the system and to dodge accountability. But, how does one dodge one's own conscience?

This should not be a controversy of pitting privacy against the right to know; rather, it should be the matching of ideals of right against wrong. But, clearly it is not that way. And, neither law nor policy for an imperfect world can be based on perfect world assumptions. Still, it is important that patients believe in and trust the integrity of those providing their health care, and in those

persons responsible for articulating the parameters within which health care is delivered. But, trust is earned, not intrinsic.

So, as health care migrates toward managed care, like it or not, the business of helping the infirm has the appearance and reality of "big business," with contracts, business deals and the delivery of health care itself being negotiated in the boardroom. Whether such a system of health care delivery is good or bad is not of central importance to this study.

But, what **is** important to note is that level of liability (or risk) is generally in direct proportion to level of responsibility. Greater responsibility implies greater risk--the stakes get higher--thus, the consequences may become greater. All of these assumptions are fundamental to competition and economic survival as hospitals and institutions compete in a managed care environment. Hospitals must be willing to assume the inherent risks of providing health care if they are to survive. Even though patients are "assigned" care in a managed care environment, I believe it is still critical that the level of care be superior without compromise. While there are other factors which can adversely affect any business, the customer's **perception** of the "product" (health care in this instance) should be a high priority. Without trust in a company,

system or service, failure is eminent.

The pressure felt by health care institutions to continually look for innovative ways to earn (and maintain) the community's trust is no doubt quite powerful. Hence, the real need for hospitals, clinics **and** health care providers to realize the potentially devastating economic impact any adverse publicity might cause, particularly as it relates to a patient's life being compromised because of possible HIV-exposure **within that facility**. Realizing it is one thing. . .doing something about it is quite another.

The process of formulating policies and laws to protect the identity of an HIV-positive physician, while protecting the patient, presents complex issues for consideration. As this thesis has indicated, those charged with this responsibility will most certainly face a myriad of difficult questions and dilemmas.

While it is difficult to predict the exact direction and consistency of those decisions, perhaps policy formulators would fare better if they do not get "bogged down" in the see-saw rhythm inherent to the issues discussed in this study.

Rather, I present for consideration, the words written during the 1993 *Hershey* appeal. As the original decision was upheld, the Supreme Court of Pennsylvania advised:

"No principle is more deeply embedded in the law
than that expressed in the maxim:

'Salus Populi Suprema Lex.'

The welfare of the people is the supreme law. . .
and a more compelling and consistent application
of that principle than the one presented here
could be quite difficult to conceive."

NOTES PART V

1. *United States v. Westinghouse Electric Corp.* (638 F.2d 570 [1980]).
2. *School Board of Nassau County v. Arline*, 480 U.S. 273, 107 S. Ct. 1123, 94 L.Ed. 2d 307, (1987).
3. *Estate of William Behringer, MD v. The Medical Center at Princeton*, 592 A.2d 1257 (N.J. Super.L. 1991).
4. Ibid., 1251.
5. Ibid., 1255.
6. *Canterbury v. Spence*, 464 F2d 772 (CA DC) cert den 409 U.S. 1064 (1972)., op cit, Lunde, Janice K., "Informed Consent and the HIV-Positive Physician," Medical Trial Quarterly, p. 191, Winter, 1991.
7. The Americans with Disabilities Act, Pub.L.No. 101-336,104 Stat.327.
8. AMA, Statement of HIV-infected Physicians (January 17, 1991).
9. Ibid.
10. *In re Application of the Milton S. Hershey Medical Center of the Pennsylvania State University v. John Doe, MD.*, 634 A2d 159 (Pa. 1993).
11. *Virgil v. Time, Inc.*, 527 F2d. 1122, 1124 (9th Cir.1975).
12. *Faya v. Almaraz*, [329 Md. 435, 620 A2d 327 (1993)].
13. Ibid.
14. *Doe v. University of Maryland Medical System Corp.*, 50 F.3d 1261, (4th Cir. 1995).
15. Ibid.

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